Neuropsychological Consultants, Inc.

WISCONSIN HIPAA PRIVACY NOTICE FORM

Notice of
Neuropsychological Consultants, Inc.
Policies and Practices to Protect the Privacy of Your Health Information

By signing below, I acknowledge that I have read the HIPAA Privacy Notice Form for *Neuropsychological Consultants, Inc.* I have had the opportunity to ask questions about that information, have had those questions answered to my satisfaction, and further indicate that I understand the content of the Privacy Notice.

I have asked for and received a copy of the *Neuropsychological Consultants, Inc.,* Wisconsin HIPAA Privacy Notice.

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of to their home.

I wish to be contacted in the following manner (initial all that apply):

____ Home Telephone _____ (initial)

_____ Written Communication (initial)

OK to leave message with call-back number

OK to mail to my home address

____ Other Telephone _____ (initial)

_____ Other_____ (initial)

OK to leave message with call-back number

_____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

_____
Guardian Signature, if needed.